Revised October 13, 2004

Pediatric Severe Influenza Case History Form

Patients must be 1) 0-17 years; 2) have confirmed influenza by laboratory testing; and 3) have been hospitalized in the PICU OR expired at any location (e.g. hospital, ER, home, etc).

Patient Information:

Last name _____ First name_____ DOB ____/_____/____ Medical Record #_____

Street Address: _____ City _____ Zip Code _____

Sex: ☐ Female ☐ Male **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black ☐ Native American ☐ Asian/Pacific Islander ☐ Other ☐ Unknown

Date onset of symptom(s): _____/_____/_____

Level of medical care (check all that apply):

☐ Outpatient clinic ☐ ER ☐ Inpatient Ward

☐ PICU ☐ None

If hospitalized, date of admission: _____/_____/____

Symptoms that occurred during the current illness:

☐ Fever ≥38º ☐ Seizures ☐ Apnea

☐ Altered consciousness ☐ Nausea/vomiting

☐ Lower respiratory symptoms (cough, shortness of breath, wheezing, bronchospasm)

☐ Other specify_____

Complications that occurred during the acute illness:

☐ Pneumonia/ARDS ☐ Croup

☐ Bronchiolitis ☐ 2˚ bacterial pneumonia

☐ Encephalitis/encephalopathy ☐ Myocarditis

☐ Reye Syndrome ☐ Sepsis/Multi-organ Failure

☐ Other specify _____

Significant Past Medical History

Cardiac disease	☐ Yes	☐ No	☐ Unk
Chronic pulmonary disorder (e.g. asthma, cystic fibrosis)	☐ Yes	☐ No	☐ Unk
Immunosuppression (e.g. HIV, malignancy):	☐ Yes	☐ No	☐ Unk
Metabolic disorder (e.g. DM, renal)	☐ Yes	☐ No	☐ Unk
Neuromuscular disorder	☐ Yes	☐ No	☐ Unk
History of febrile seizures	☐ Yes	☐ No	☐ Unk
Seizure disorder	☐ Yes	☐ No	☐ Unk
Developmental delay:	☐ Yes	☐ No	☐ Unk
Hemoglobinopathy (e.g. SCD):	☐ Yes	☐ No	☐ Unk
Long -term aspirin therapy:	☐ Yes	☐ No	☐ Unk
Steroids by mouth/injection:	☐ Yes	☐ No	☐ Unk
Cancer chemotherapy	☐ Yes	☐ No	☐ Unk
Radiation therapy	☐ Yes	☐ No	☐ Unk
Other immunosuppressive meds:	☐ Yes	☐ No	☐ Unk
Pregnant:	☐ Yes	☐ No	☐ Unk #weeks:_____
Other conditions:	☐ Yes	☐ No	☐ Unk

If YES for any of the above, please specify:

_____

_____

_____

Influenza Vaccination Status:

Was the patient vaccinated this season (inactivated or LAIV-FluMist)? ☐ Yes ☐ No ☐ Unk

If yes, approximate dates:

1st dose ___/____/____ ☐ Inactivated ☐ FluMist

2nd dose (if done): ___/____/____ ☐ Inactivated ☐ FluMist

Did the patient receive any influenza vaccine in previous seasons? ☐ Yes ☐ No ☐ Unk

Diagnostic/Laboratory Studies (specify details):

CBC: Hct _____ Plt _____ WBC_____

Chest X-ray: ☐ Pos ☐ Neg ☐ Not done

Findings: _____

Cardiac echo: ☐ Pos ☐ Neg ☐ Not done

Findings: _____

Lumbar puncture: ☐ Pos ☐ Neg ☐ Not done

Findings:_____

Influenza/microbiology Testing:

Rapid influenza test: ☐ Pos ☐ Neg ☐ Not done

Rapid RSV test: ☐ Pos ☐ Neg ☐ Not done

If testing confirmed influenza type, specify:

☐ Influenza A ☐ Influenza B ☐ Not done

Blood culture: ☐ Pos ☐ Neg ☐ Not done

If positive, specify pathogen:_____

Respiratory culture: ☐ Pos ☐ Neg ☐ Not done

If positive, specify specimen (n-p swab, n-p wash, o-p swab, ET aspirate, sputum, BAL, pleural fluid) and pathogen:

_____

Other pertinent labs (LFTs, MRI/CT, etc.), if available

_____

_____

Clinical course:

Antibiotics/antivirals received (if any) and dates:

_____

_____

If hospitalized, intubated? ☐ Yes ☐ No ☐ Unk

Died*: ☐ Yes ☐ No ☐ Unk

* If died, please complete Pediatric Death Supplemental Form

Physician/Infection Control Practitioner Contact Info:

Name: _____

Facillity:_____

Pager:_____Fax:_____

e-mail:_____

TO REPORT A CASE, PLEASE CALL SAN DIEGO COUNTY COMMUNITY EPIDEMIOLOGY DIVISION AT 619-515-6620,

AND FAX THIS FORM TO: (619) 515-6644

For questions, contact your local county health department or the California Department of Health Services Immunization Branch [Janice Louie, MD or Trevor Shoemaker, MPH at 510-540-2065)